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ABSTRACT

To assess patient preferences for male as opposed to female physicians, 120 adults were asked to complete a questionnaire. The results indicated that preference for male versus female physicians was influenced by three factors: gender of respondent, nature of the clinical complaint, and specified physician attributes. Overall, the responses suggested a preference for same-gender physicians. (FL)

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Close Encounters of the Medical Kind: Attitudes Toward Male and Female Physicians

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Clinical medicine in this country has long been male dominated [1] and our social reality has been constructed accordingly [2]. Many years ago in China, when modesty was the mode, physical exams were performed vicariously as women patients pointed out anatomical areas of concern on dolls designed for such use. Today, in this country, our medical social reality is predicated on a "nothing unusual is happening" stance [3] which promotes an asexual paternalistic image of physicians as healers. Thus men and women in this country have long been habituated to exposing their bodies to and being examined by male physicians. But how do we feel about being examined and treated by women physicians? Have we succeeded in inculcating an image of physicians as genderless healers or are we aware of and differentially responsive to the gender of our physicians? If so, under what circumstances might gender become a significant variable in one's selection of a physician?

Such questions take on relevance as we note the dramatic increase of women entering and graduating from medical schools over the past seven years [4]. Gordon's study of 1975-1976 students enrolled in United States medical schools indicates that 23.6% were women. At this current rate of enrollment, approximately 3500-4000 women are graduating from medical school each year. This has been coupled with trends toward women physicians branching into a greater variety of medical specialties [5] creating potential for contact with a greater diversity of patients than ever before (e.g., gender, age, type of presenting clinical complaint, etc.). For years pediatrics was the most popular specialty choice of women physicians in the United States thus limiting their patient contact largely to children and mothers. However, present indices indicate that soon there will be many more women in the medical marketplace spanning more specialty areas and in greater numbers.

But despite the greater number of women entering medicine, little research has been directed to the study of attitudes toward or receptivity to women physicians. In fact, a search of the literature has failed to produce any current studies conducted in this area per se.

In an effort to provide some groundwork in this area, we launched a preliminary study to assess preferences for male vs. female physicians. The results, although based on a relatively small and idiosyncratically selected sample [6], provided suggestive evidence that physician gender does affect one's physician preference. Specifically, respondents indicated a unilateral preference for same-gender physicians. This tendency was strongest for items in which the patient complaint involved a sexual dysfunction. Items involving a thorough physical exam also elicited strong same-gender physician preferences.

The purpose of this present study is to continue the earlier work using a larger and more representative sample of respondents and also incorporate the variable of respondents' age. Results from the preliminary study suggest that patient age might affect their physician preferences. It was hypothesized that older patients may be more entrenched in or habituated to medicine as a male profession and thus more inclined, regardless of other circumstances, to prefer a male physician.

Specifically, we were interested in the following questions: (1) Does gender of the patient influence his/her preference for a male vs. female physician? (2) Does age of the patient influence his/her preference for a male vs. female physician? (3) Do patients' physician preferences vary depending on certain physician attributes unrelated to physician gender? (4) Do such preferences vary as a function of the nature of the presenting clinical complaint(s)?

PHYSICIAN PREFERENCE QUESTIONNAIRE

We elected to study preferences regarding physician gender as a function of the presenting clinical complaint and certain physician attribute variables. The Physician Preference Questionnaire, validated in the preliminary study, included four presenting clinical complaint variables and eight sets of physician attribute variables. The four clinical complaints ranged in degree of potential medical seriousness and personal intimacy and included (1) sore throat and fever (2) thorough physical exam (3) sexual dysfunction (4) blood in urine. The eight sets of physician attribute variables subsumed the four clinical complaints yielding a total of 32 separate items. The physician attribute sets encompassed the dimensions of degree of physician recommendation, physician availability, and age of physician. (We purposely decided not to include a physician personality or "likeableness-empathy" dimension since these are some of the very qualities we wanted respondents to infer based on their own biases and experiences regarding physician gender.)

The eight sets of physician attribute variables included:

Set I: Assume that both male and female physician are highly recommended to you and both can see you immediately.

Set II: Assume that the male physician is highly recommended while you know little about the female physician other than one of your friends goes to her.

Set III: Reverse of Set II.

Set IV: Assume that you know nothing about the qualifications of either physician. You received only their names from an acquaintance.

Set V: Assume that the female physician can see you immediately while the male physician cannot see you for a week.

Set VI: Reverse of Set V.

Set VII: Assume that the male physician is middle-age (40's-50's) and the female physician is in her early 30's).

Set VIII: Reverse of Set VII.

Participants were instructed to assume that they had just moved to a new town and were in need of medical services. They were then asked to read each of the 32 questionnaire items and to indicate their physician preference for each item on a 5-point Likert-type scale. The questionnaire was scaled as follows: "5" strongly prefer female; "4" slightly prefer female; "3" no preference; "2" slightly prefer male; "1" strongly prefer male.

SUBJECTS

In response to criticism of a relatively small and idiosyncratically selected population pool for the preliminary study, in the present investigation we sought a larger and more uniformly selected sample. Therefore, participants for this study consisted of applicants who answered a local newspaper advertisement soliciting "programmed patients" for the medical school clinical skills student training program.

Of those who answered the ad and subsequently showed up for a personal interview, 120 people volunteered to fill out the Physician Preference Questionnaire after completing their job interview. Participation was voluntary and questionnaires were returned anonymously. Participants ranged in age from 18 to 70 years, the mean being 35, and included 45 males and 75 females.

For the statistical analysis in which age was analyzed as one of the main effects, patients were divided into two groups--those under 35 and those over 35. Of the 45 males, 27 were under 35 and 18 were over 35. Of the 75 women, 45 were under 35 and 30 were over 35. Thirty-five was selected as the cut-off

age since it appeared to be the natural statistical dividing point of this sample, i.e., being the mean age and standing alone, with no one 34 or 36 years old.

RESULTS

Means were tabulated for male and female participants separately for each of the items and compared by *t* tests. We then conducted five ANOVAs comparing preferences of male and female participants (1) across four groups of physician attribute sets (2) across the four presenting clinical complaints, summing each participant's responses over the eight physician attribute sets.

INSERT Table 1

Inspection of means indicates that of the four clinical complaint items, all but "sore throat and fever" indicated a tendency toward preference for a same-gender physician across all eight physician attribute variables. Sexual dysfunction elicited the most polarity between male and female respondents (Male *M* = 2.359 and Female *M* = 3.081). Sore throat produced the least amount of polarity (Male *M* = 2.986 and Female *M* = 2.968). Physician recommendation and physician availability variables were found to influence preferences for male vs. female physicians most for routine problems (sore throat) or potentially serious and acute problems (blood in urine).

Analysis 1: No Physician Attribute Information

An ANOVA was conducted to assess preference for male vs. female physicians given no supplementary physician attribute data. The results produced a statistically significant effect due to patient gender $F(1,116) = 22.888$, $p < .001$.

This indicates a tendency for male and female respondents to prefer physicians of their own gender regardless of other physician attributes. Age was not found to be a significant main effect.

Analysis 2: Recommendation

A three-way ANOVA was conducted for gender of respondent, age of respondent, and three physician recommendation conditions (i.e., male highly recommended, female highly recommended, both highly recommended). The main effects due to gender $F\ (1,116) = 26.6323$, $p < .001$ and recommendation $F\ (2,232) = 168.9271$, $p < .001$ were significant. The significant recommendation effect reflects a tendency for both sexes to vary the degree of their preferences depending upon which physician is more highly recommended. The failure to obtain a significant sex by recommendation effect ($p < .05$) suggests that the degree of their preference shifts was comparable for the two sexes.

Analysis 3: Physician Availability

A 2 x 2 x 2 ANOVA was conducted including sex of respondent, age of respondent, and two conditions of physician availability (i.e., female can see you immediately but male cannot see you for a week and the reverse). Again the main effects due to gender $F\ (1,116) = 5.5908$, $p < .05$ and set availability $F\ (1,116) = 353.095$, $p < .001$ were significant. However, none of the interactions were significant nor was the main effect for age.

Analysis 4: Physician Age

This analysis included a 2 x 2 x 2 ANOVA to assess the effects of respondents' gender and age and physician age on respondents' physician preferences. This analysis yielded a significant main effect due to gender $F\ (1,116) = 24.2041$, $p < .001$ though the other two main effects were not significant nor were the interactions. Thus, regardless of physician age, participants indicated a preference for a physician of their same sex.

Analysis 5: Clinical Complaint

A final 2 x 2 x 2 ANOVA was conducted covering sex of respondent, age of respondent, and the four presenting clinical complaints (i.e., sore throat and fever, physical exam, sexual dysfunction, and blood in urine). As in all previous analyses, sex of respondent was found to be a significant determinant of physician preference $F(1,116) = 18.9565$, $p < .001$. None of the other main effects or interactions were found to be significant.

DISCUSSION

Results of this study indicate that preference for male vs. female physicians was influenced by three of the four experimental factors. Gender of respondent, nature of the clinical complaint, and specified physician attributes all seem to affect one's physician preferences. Age of respondent (as analyzed using 35 as the dividing age) did not appear to be a significant differentiating variable. Overall, responses suggest a unilateral preference for same-gender physicians on all but a few items (Male response total $M = 2.630$ and Female response total $M = 3.162$). These results are almost identical to the results obtained in the preliminary study.

There was greatest polarity between male and female responses across the sexual dysfunction clinical complaint item with thorough physical exam eliciting the next most response polarity and sore throat eliciting the least polarity. These results seem to indicate that despite our relatively liberal society and efforts to depict physicians as asexual, patients are aware of physician gender and prefer a same-sex physician when their presenting complaint is of an intimate nature or involves complete disrobing. When the clinical complaint is more superficial and does not involve undress or extensive bodily probing, the physician gender variable does not seem to

have the same impact on physician preference. In such instances, other attributes such as strength of recommendation or physician availability appear to be more important differentiating variables.

On most items, men shifted more strongly toward the male end of the continuum than women shifted toward the female end as evidenced by the row means across the physician attribute variables for three of the four clinical complaints; physical exam, Male $\underline{M}$ = 2.558 and Female $\underline{M}$ = 2.120; sexual problem, Male $\underline{M}$ = 2.359 and Female $\underline{M}$ = 3.478; blood in urine, Male $\underline{M}$ = 2.630 and Female $\underline{M}$ = 3.081. Little difference was evidenced between male and female responses for the sore throat clinical complaint items.

Looking at the "blood in urine" clinical complaint items, one might speculate that, given the potential medical seriousness of such symptoms, physician attribute variables of "recommendation" and "availability" would be stronger preference factors than physician gender. Results confirm this though males did not shift as strongly toward the female end of the continuum when the female was more highly recommended and available as did females shift toward the male end when the male was more highly recommended or available. So physician gender did have some effect on respondents' physician preferences for this complaint, though it did not appear to exert the strongest influence.

Aside from having been habituated to male physicians, perhaps these results may be a product of the dual roles which men must assume when tended by a woman physician. Males in this country are stereotypically defined and taught to define themselves as dominant, active, strong, virile, etc., while women are stereotypically defined as assuming a less dominant, more passive, delicate, modest role. Thus a male patient who must disrobe and be examined and handled by a woman physician must assimilate two perhaps competing roles; he is societally defined as the more agressive and dominant of the two but as

patient must sometimes assume a more passive, compliant role as the female physician "takes charge of his body." Therefore, male patients may be the more reluctant to be treated by women physicians for problems involving extensive handling, probing, and undressing.

Women, on the other hand, have long been habituated to male physicians. Further, a male doctor can assume both the male qualities of strength, dominance, authority, assertiveness, etc., as well as the healer role qualities of paternalism and protectiveness without arousing any inner role conflicts in either doctor or patient. This may be one reason why women seem to be less adamant in their preferences for same-gender physicians than are men.

Thus evidence suggests that we are aware of physician gender and that "something very unusual is happening" in medical encounters. That is, we effect a "nothing is happening" demeanor in order to sustain the current definition of the situation and avoid overt acknowledgement of what might otherwise be experienced as uncomfortable and embarassing interaction. What are the implications of all of these findings? First of all, some pedagogical concerns emerge. Perhaps women physicians need to be sensitized to potential patient reluctance toward women doctors. That is, they need to be taught and encouraged to develop constructive communication skills for coping with and hopefully reversing any such patience reluctance. Secondly, when women patients have certain types of medical concerns, evidence suggests a preference to be treated by a same-gender physician. This presents a need for more women physicians in such specialty areas as OBGYN, surgery, family practice, internal medicine, etc. One last point, the media tends to represent medicine as a male dominated profession though this is changing somewhat.

Perhaps there is a need for widespread media campaigns to revamp our image of medicine and doctors. Women need to be depicted more frequently and realistically in the role of physician. Such efforts will aid in acclimating us to accept women as competent physicians.

Table 1

Mean Preference Scores by Male and Female Respondents

	Both Recommended	Male Recommended	Female Recommended	No Information	Male Available	Female Available	Male Middle Age	Female Middle Age	Row Means
Sore Throat									
Male	3.021	2.234	3.787	2.936	1.383	4.660	2.894	2.979	2.986
Female	2.987	1.933	3.907	2.973	1.267	4.760	2.907	3.013	2.968
Physical Exam									
Male	2.255	2.064	3.234	2.468	1.723	3.702	2.596	2.426	2.558
Female	3.133***	2.187	4.027***	3.080***	2.040	4.120*	3.067**	3.307***	3.120
Sexual Problem									
Male	2.128	1.851	3.000	2.170	1.596	3.319	2.574	2.234	2.359
Female	3.573***	2.893***	4.107***	3.440***	2.560***	4.187***	3.467***	3.600***	3.478
Blood in Urine									
Male	2.353	1.851	3.447	2.532	1.447	4.340	2.660	2.383	2.630
Female	3.120***	2.093	4.067***	3.053**	1.453	4.680*	2.907	3.280***	3.081
Row Means									
Male	2.446	2.000	3.367	2.526	1.537	4.005	2.681	2.505	2.630
Female	3.203	2.276	4.027	3.136	1.830	4.436	3.087	3.3	3.162

NOTE: Remember that scores tending toward "1" indicate a strong preference for a male physician and scores tending toward "5" indicate a strong preference for a female physician.

[a]Significant differences between male and female means are indicated by asterisk(s) adjacent to female means for each item.

*p .05

**p .01

***p .001

REFERENCES

1. Ris H. W. What do woman want? Women Physician, Vol. 29, 446-454, 1974.
2. Only three other nations have a lower number of women physicians than the United States. They include Spain, Madagascar, and South Vietnam.
3. Emerson J. P. Nothing unusual is happening. In Human Nature and Collective Behavior: Papers in Honor of Herbert Blower. (Edited by Tamutsu Shibutani) Prentice-Hall, Englewood Cliffs, New Jersey, 1970.
4. Gordon T. L. Descriptive study of medical school applicants, 1975-1976. Association of American Medican Colleges (Tech. Rep. 231-76-0011), Washington, D.C., February 1977.
5. Pennell M. T. and Renshaw J. E. Distribution of women physicians. Journal of the American Medical Women's Assoc., Vol. 28, 181-186, 1973.
6. Ackerman-Ross F. S. and Sochat N. Effects of patients' sex on attitudes toward male and female physicians. Paper presented at the International Communication Association Convention, Chicago, May 1978.